U.S. Department of Labor

Office of Administrative Law Judges
Seven Parkway Center - Room 290
Pittsburgh, PA 15220

(412) 644-5754
(412) 644-5005 (FAX)

Issue Date: 28 November 2006

CASE NO. 2004-BLA-6803

In the Matter of

F.J.L. .
Claimant

v.

ISPAT INLAND, INC.,
a/k/a INLAND STEEL COAL COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:

Robert J. Bilonick, Esquire
For the Claimant

John J. Bagnato, Esquire
For the Employer

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER-DENYING BENEFITS

This proceeding arises from a claim for benefits filed by F.J.L., a former coal miner, under the Black Lung Benefits Act, 30 U.S.C. §901, *et seq*. Regulations implementing the Act have been published by the Secretary of Labor in Title 20 of the Code of Federal Regulations.[1]

[1] The Secretary of Labor adopted amendments to the "Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969" as set forth in Federal Register/Vol. 65, No. 245 Wednesday, December 20, 2000. The revised

Black lung benefits are awarded to coal miners who are totally disabled by pneumoconiosis caused by inhalation of harmful dust in the course of coal mine employment and to the surviving dependents of coal miners whose death was caused by pneumoconiosis. Coal workers' pneumoconiosis is commonly known as black lung disease.

A formal hearing was held before the undersigned on February 28, 2006, in Hollidaysburg, Pennsylvania. At that time, all parties were afforded full opportunity to present evidence and argument as provided in the Act and the regulations. Furthermore, the record was held open to allow for the submission of written closing arguments by the respective parties to be postmarked on or before April 14, 2006 (TR 33-34).

At the formal hearing, the following documents were admitted in evidence: Director's Exhibits 1 through 54; Claimant's Exhibits 1 through 15, except for Claimant's Exhibits 5, 10, and 12; and, Employer's Exhibits 1 through 7, except for Employer's Exhibit 4. However, Claimant's Exhibit 5 was withdrawn based upon the assumption that it was already admitted into evidence as Director's Exhibit 35 (TR 12). Upon review of District Director's Exhibit 35, I note that it consists of a cover letter by Claimant's counsel, dated March 11, 2004, which refers to an enclosed x-ray interpretation by Dr. Brandon of a chest x-ray, dated September 15, 2003, as well as Dr. Brandon's curriculum vitae. However, Dr. Brandon's x-ray reading and curriculum vitae are not contained in Director's Exhibit 35 (DX 35). Accordingly, I have *sua sponte* admitted Claimant's Exhibit 5 (CX 5).

In summary, the record consists of the hearing transcript, Director's Exhibits 1 through 54 (DX 1-54), Claimant's Exhibits 1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 13, 14, 15 (CX 1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 13, 14, 15), and Employer's Exhibits 1, 2, 3, 5, 6, 7 (EX 1, 2, 3, 5, 6, 7).

The findings of fact and conclusions of law which follow are based upon my analysis of the entire record, including all documentary evidence admitted, testimony presented, and arguments made. Where pertinent, I have made credibility determinations concerning the evidence.

Procedural History

On October 18, 2002, Claimant filed the current application for black lung benefits under the Act (DX 2). On May 5, 2003, the District Director issued a Proposed Decision and Order denying benefits. Although the District Director found that Claimant had established the presence of pneumoconiosis, and that the disease was caused, at least in part, by his coal mine employment, he denied benefits based upon Claimant's failure to establish that the disease caused a totally disabling pulmonary or respiratory impairment (DX 21). Following Claimant's timely request for a formal hearing (DX 14), this matter was initially referred to the Office of Administrative Law Judges in July 2003 (DX 25-27).

Part 718 regulations became effective on January 19, 2001. Since the current claim was filed on October 18, 2002 (DX 2), the new applications are applicable (DX 27, 54).

A formal hearing was scheduled to be held before Administrative Law Judge Daniel L. Leland on May 3, 2004. However, Employer's counsel requested a continuance in order to investigate the claim and develop a defense, if appropriate. In the absence of any objection by Claimant's counsel, Judge Leland issued an Order of Continuance, dated March 11, 2004 (DX 33). By letter, dated April 15, 204, Claimant's counsel advised Judge Leland that, in view of Employer's development of medical evidence, he would probably need time to develop rebuttal medical evidence. Accordingly, Claimant's counsel requested that the claim be remanded to the Claims Examiner (DX 38). Pursuant to Claimant counsel's request, and in the absence of an objection by Employer's counsel, Judge Leland issued an Order of Remand, dated April 19, 2004, in which he remanded the case to the District Director "to allow for further evidentiary development of the case." (DX 39).

On remand, the District Director allowed the further development of medical evidence, as provided in Judge Leland's Order of Remand. However, the District Director's office re-characterized the remand as a request for modification (DX 42). On August 12, 2004, the District Director issued a document entitled – "Proposed Decision and Order on Remand Denial of Modification of Prior Decision" (DX 47). In summary, the District Director considered the additional medical evidence presented, and concluded that the prior determination should not be changed. Thus, the District Director's office, again, found the presence of pneumoconiosis and its causal relationship to coal mine employment, but also reiterated its finding that total disability was not established (DX 47). Following Claimant's timely request for a formal hearing (DX 49), the case file was returned to the Office of Administrative Law Judges for adjudication (DX 52-54). As stated above, a formal hearing was held on February 28, 2006 and the record was held open until April 14, 2006.

Issues

I. Whether the miner has pneumoconiosis as defined by the Act and the regulations?
II. Whether the miner's pneumoconiosis arose out of coal mine employment?
III. Whether the miner is totally disabled?
IV. Whether the miner's disability is due to pneumoconiosis?
V. Whether the evidence establishes a change in conditions and/or a mistake in a determination of fact per 20 C.F.R. §725.310?

(DX 52; TR 8-9).

Findings of Fact and Conclusions of Law

I. Background

A. Coal Miner and Length of Coal Mine Employment

On the application for benefits form, Claimant alleged 22 years of coal mine employment ending on January 7, 1986, when he was laid off (DX 2). However, on the Employment History

form, Claimant stated that he stopped working in July 1986 (DX 3). Furthermore, Claimant testified that he worked for Employer for 23 years (TR 23). On the other hand, the District Director found that the Social Security records establish that Claimant engaged in coal mine employment for 21.26 years (DX 8).

The parties stipulated, and I find, that Claimant established at least 21 years of coal mine employment (TR 23-24). Moreover, the slight discrepancies cited above regarding the exact number of years of coal mine employment is inconsequential for the purpose of rendering this decision.

B. Date of Filing

Claimant filed his current claim for benefits under the Act on October 18, 2002 (DX 2). Although Claimant filed the claim more than 16 years after he left coal mine employment, the presumption of timeliness has not been rebutted. 20 C.F.R. §725.308(c).

C. Dependents

Claimant has one dependent for the purpose of possible augmentation for benefits under the Act (DX 2, 11; TR 23).

D. Responsible Operator

Employer, Ispat Inland, Inc., a/k/a Inland Steel Coal Co., is the properly designated responsible operator (DX 1, 3, 7, 8; TR 26-27).

E. Personal, Employment, and Smoking History

Claimant was born on January 13, 1935. As stated above, Claimant engaged in coal mine employment for at least 21 years ending in 1986, when he was laid off because the mine shut down (DX 2; TR 23). On the "Description of Coal Mine Work and Other Employment" form, Claimant stated that his last usual coal mine job, as a "Load Out Operator," entailed the following daily physical activities: Sitting for 4 hours; Standing for 2 hours; Lifting items weighing 80, 40 and 20 pounds, 5, 3, and 2 times, respectively; Carrying items weighing 40, 80, and 20 pounds distances of 200 ft, 100 ft, and 100 ft, respectively (DX 4). At the formal hearing, Claimant testified that his last usual coal mine job entailed manual lifting of props weighing 30, 40, or 50 pounds, as well as cleaning spillage in the crusher room (TR 24-25). Taken as a whole, I find that Claimant's last usual coal mine job required significant periods of moderately heavy physical exertion.

After leaving the coal mines in 1986, Claimant worked in maintenance at Laurel Crest Nursing Home (DX 4; TR 27). On the "Description of Coal Mine Work and Other Employment" form, Claimant had stated that his non-coal mine work as a "Maint Supervisor" entailed the following daily physical activities: Sitting for 4 hours; and, Lifting items weighing 80 pounds 2 times per day (DX 4). At the formal hearing, Claimant initially testified that his maintenance job involved physical work. However, Claimant also testified that there was no

physical work except for climbing stairs when the fire alarm went off. Moreover, Claimant testified that his coal mine work involved substantially more exertion (TR 27-28). Taken as a whole, I find that Claimant's post-coal mine work was not comparable to his last usual coal mine job. Moreover, even assuming that it entailed similar physical exertion, Claimant stopped working in 1999 (DX 4; TR 28).

Claimant testified that he suffers from worsening breathing difficulties which he first noticed in 1983 (TR 26). Claimant stated that he still goes hunting while using a four-wheeler to ride in. However, he no longer mows the lawn or gardens (TR 30). Claimant testified that he has been treated by Dr. Dvorchak, his family physician, for more than ten years. Dr. Dvorchak has, on occasion, administered chest x-rays and conducted breathing tests (TR 28-29). Claimant testified that he always complains to Dr. Dvorchak about his breathing problems, and that he has been using Advair since 1984. Claimant noted that Dr. Dvorchak had increased the dosage once since 1984 (TR 29).[2]

Claimant stated that he could never return to coal mine employment because of his breathing condition (TR 30). In addition to complaints of shortness of breath and daily coughing spells each morning, Claimant testified that he had right knee replacement surgery within the past five years. However, Claimant stated that he has not had any heart attacks, strokes, or any other major illnesses. Moreover, Claimant testified that he has never smoked (TR 28-31).

II. Medical Evidence

The medical evidence includes various chest x-rays, pulmonary function studies, arterial blood gases, and physicians' opinions, as summarized below.

A. Chest X-rays

The record contains interpretations of chest x-rays dated December 3, 2002 (DX 13;[3] CX 3; EX 1), September 15, 2003 (DX 28, 41; CX 5), July 23, 2004 (CX 14; EX 2), and October 29, 2004 (CX 13; EX 3), respectively.

Of the numerous substantive readings, six are positive for pneumoconiosis under the classification requirements set forth in §718.102(b); namely, the interpretations by Dr. Pickerill (1/1, t/t, in lower 2 zones) and Dr. Harron (1/0, s/p, in all six zones) of the December 3, 2002 x-ray (DX 13; CX 3); the readings by Dr. Schaaf (1/0, p opacities, in lower 4 zones) and Dr. Brandon (1/1, q/s, in 2 upper zones) of the September 15, 2003 x-ray ((DX 28; CX 5); Dr. Harron's (1/0, s/t, in lower 4 zones) interpretation of the July 23, 2004 x-ray (CX 14); and, Dr. Harron's (1/0, s/t, in lower 2 zones) reading of the October 29, 2004 (CX 13). Of the foregoing, Drs. Pickerill, Harron, and Brandon are B-readers. Moreover, Drs. Harron and Brandon are dual-qualified B-readers and Board-certified radiologists (CX 4, 6).

[2] Dr. Dvorchak reported that he has treated Claimant since January 12, 1988 (CX 15). This suggests that either a different physician initially prescribed Advair, or that Claimant started using the medication later than he thought.

[3] Dr. Barrett, a B-reader and Board-certified radiologist, interpreted the December 3, 2002 x-ray for film quality only. He reported the film quality as "1" (*i.e.,* Good). (DX 13).

On the other hand, the record includes four negative interpretations; namely, Dr. Wolfe's (0/0) readings of the films, dated December 3, 2002 (EX 1) and September 15, 2003 (DX 41); and, Dr. Solic's (0/1, s/t, in 2 lower zones) interpretations of the chest x-rays, dated July 23, 2004 (EX 2) and October 29, 2004 (EX 3), respectively. Moreover, Drs. Wolfe and Solic are B-readers. Furthermore, Dr. Wolfe is a dual-qualified B-reader and Board-certified radiologist (CX 4, 6).

In summary, the record contains conflicting interpretations of several chest x-rays by similarly well-qualified B-readers and/or Board-certified radiologists. Moreover, the conflict is not limited to "positive" versus "negative" interpretations. As outlined above, there is disagreement among the "positive" readers regarding the shape/size, profusion, and location of the small opacities. Furthermore, Dr. Harron's own positive x-ray interpretations indicate an improvement which is inconsistent with the progressive and irreversible nature of pneumoconiosis. Similarly, the findings of the "negative" readers are also conflicting. In view of the foregoing, I find that the x-ray evidence neither precludes nor establishes the presence of pneumoconiosis. Accordingly, despite the numerical majority of positive interpretations, I find that Claimant has failed to meet his burden of establishing pneumoconiosis by a preponderance of the x-ray evidence.

B. Pulmonary Function Studies

A claimant must show he is totally disabled and that his total pulmonary disability is caused by pneumoconiosis. The regulations set forth criteria to be used to determine the existence of total disability which include the results of pulmonary function studies and arterial blood gas studies.

The record contains pulmonary function studies, dated December 3, 2002 (DX 13), February 21, 2003 (DX 43), September 15, 2003 (DX 28), July 23, 2004 (EX 2), and October 29, 2004 (EX 3). None of the pulmonary function studies (before or after bronchodilator), including those in which Claimant's effort was questioned (DX 43; EX 2), are qualifying under the regulatory criteria set forth in Part 718, Appendix B. Moreover, some of the studies, including the most recent, were interpreted as "normal" (DX 13; EX 3). Accordingly, I find that the pulmonary function study evidence does not establish a totally disabling pulmonary or respiratory impairment.

C. Arterial Blood Gas Studies

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The record includes arterial blood gas studies which were administered on December 3, 2002 (DX 13), September 15, 2003 (DX 28), July 23, 2004 (EX 2), and October 29, 2004 (EX 3). None of the arterial blood gas studies (at rest and/or with exercise) are qualifying under the regulatory standards set forth in 20 C.F.R. Part 718, Appendix C. Accordingly, I find that such evidence does not establish a totally disabling pulmonary or respiratory impairment.

D. Physicians' Opinions[4]

The case file includes CT scan interpretations by Drs. Zlupko (DX 43), Karunaratne (DX 43), and Harron (CX 8, 9). In addition, the record contains other medical notes, reports and/or deposition testimony of Drs. Zlupko (DX 13, 43; EX 5), Schaaf (DX 28; CX 1, 7, 11), Cox (EX 2, 6), Solic (EX 3, 7), and Dvorchak (CX 15), respectively.

Dr. George M. Zlupko, who is Board-certified in Internal Medicine and Wound Management (DX 13), issued a "Progress Note," dated March 24, 2004, in which interpreted a CT scan of the chest, dated March 5, 2003, as follows: "showed some streaky and patchy infiltrates in middle and lower lung zones possibly representing some fibrotic scarring. In my review, I felt that the ones in the posterior aspect of the right lung base possibly showed evidence of bronchiectasis." (DX 43).

A CT scan, dated March 12, 2004, was ordered by Dr. Zlupko and conducted at Altoona Hospital. This CT scan was interpreted by Dr. E.R. Karunaratne, whose credentials are not in the record (DX 43). In summary, Dr. Karunaratne compared this CT scan with the previous one, and set forth the following findings:

> 1. Ill defined alveolar densities are seen in the lower lung fields bilaterally. Findings are likely due to pneumonic infiltrates. Some of the changes appear chronic as noted.
>
> 2. Pleural thickening is noted bilaterally. This is noted to be somewhat more prominent when compared with the previous study.
>
> 3. No pleural effusion is demonstrated.
>
> 4. There is slight prominence of the ascending thoracic aorta with maximal diameter of 4 cm. This is unchanged when compared with the previous study.

(DX 43).

Dr. Ray A. Harron, a B-reader who is Board-certified in Radiology and Nuclear Medicine (CX 4, 13, 14), provided interpretations of CT scans, dated March 5, 2003 (CX 8) and March 12, 2004 (CX 9). Dr. Harron read the initial CT scan as follows:

> IMPRESSION:
>
> 1. Pea sized opacities consistent with coal workers pneumoconiosis.
> 2. Pleural changes consistent with asbestos related disease.
> 3. Enlarged heart, see the doctor.

[4] Medical reports and/or physicians' testimony which refer to documents not in evidence are deemed to have been redacted. Unless I make a specific finding herein that the redacted data is critical to a physician's ultimate opinion, the redaction of objectionable information will not materially affect the weight I accord such opinion. *See, Harris v. Old Ben Coal Co.*, 23 BLR 1-98 (Jan. 27, 2006); *see also, Webber v. Peabody Coal Co.*, 23 BLR 1-123 (Jan. 27, 2006)(en banc).

4. Rule out neoplastic disease in both lower lung zones, see the doctor.
5. Rule out neoplastic disease in both lower esophagus, see the doctor.

(CX 8). Similarly, Dr. Harron interpreted the CT scan, dated March 12, 2004, as follows:

IMPRESSION:

1. Pea sized opacities consistent with coal workers pneumoconiosis.
2. Changes consistent with asbestos related disease.
3. Enlarged heart, see the doctor.
4. Rule out neoplastic disease lower lung zones an in the GI Tract, see the doctor.

(CX 9).

Dr. Zlupko also conducted a pulmonary evaluation of Claimant on December 3, 2002 (DX 13), with follow-up office visits until June 2003 (DX 43; CX 5). Dr. Zlupko was selected by the Claimant from a list of qualified providers (DX 12). On a U.S. Department of Labor form, Dr. Zlupko reported the results of his December 3, 2002 evaluation (DX 13). Dr. Zlupko set forth a coal mine employment history from October 1964 to July 1986, and listed Claimant's last usual coal mine job as a "Load out operator" (DX 13, Sec. B). Dr. Zlupko also reported Claimant's family, medical, and social histories. The latter included a notation that Claimant had never smoked (DX 13, Sec. C3). Claimant's subjective complaints included sputum, wheezing, dyspnea, cough, chest pain, and orthopnea (DX 13, Sec. D1). On physical examination, Dr. Zlupko found, in pertinent part, that the results were within normal limits (DX 13, Sec. D4). Furthermore, Dr. Zlupko administered various clinical studies, including chest x-ray, pulmonary function study, arterial blood gas, and EKG (DX 13, Sec. D5). Under the Cardiopulmonary Diagnoses section of the U.S. Department of Labor form report, Dr. Zlupko set forth the following: "Radiographic evidence suggestive of mild simple pneumoconiosis without any evidence of pulmonary dysfunction on pulmonary function testing." (DX 13, Sec. D6). Regarding the etiology of the foregoing diagnosed condition, Dr. Zlupko noted: "coal dust exposure during his working career" (DX 13, Sec. D7). When asked the severity of Claimant's impairment from a chronic respiratory or pulmonary disease, if any, Dr. Zlupko stated: "Pt. Has no evidence of pulmonary function impairment on pulmonary function testing" (DX 13, Sec. 8a). On the other hand, Dr. Zlupko listed various disabling non-respiratory conditions, including, history of prostate cancer, osteoarthritis, and hearing loss (DX 13, Sec. 9).

In addition to the above-referred pulmonary evaluation and CT scan interpretations, Dr. Zlupko's office notes indicate that Dr. Zlupko suspected that Claimant had pneumonia in December 2002, or possibly rheumatoid arthritis. Furthermore, Dr. Zlupko noted that Claimant had a positive TB skin test with no obvious symptoms (DX 43; EX 5).

Dr. John T. Schaaf, who is Board-certified in Internal Medicine, Pulmonary Disease, and Critical Care Medicine (CX 2), examined Claimant on September 15, 2003 (DX 28; CX 1). On that date, Dr. Schaaf issued a report entitled "New Patient Consultation Note," in which he set forth Claimant's history of present illness, past medical history, family history, and review of systems. Dr. Schaaf noted Claimant's subjective complaints of shortness of breath, wheezing,

coughing, and spitting. Dr. Schaaf also reported Claimant's coal mine employment history, and subsequent non-coal mine work ending in 1999 "because of breathlessness." Furthermore, he reported that Claimant never smoked. In addition, Dr. Schaaf conducted a physical examination, including chest. The reported findings were as follows: "Resonant, symmetrical, nontender. Breath sounds were normal and there was no wheezing heard even during forced exhalation." Dr. Schaaf also administered a chest x-ray and pulmonary function tests. As stated above, Dr. Schaaf interpreted the x-ray as positive for (1/0, p, in four lower lung zones) pneumoconiosis. Dr. Schaaf's stated that the pulmonary function tests "demonstrate a forced vital capacity of 75% predicted, FEV-1 is 86% predicted, FEV-1/FVC ratio is 78%. These are findings of restrictive disease, no obstructive disease was demonstrated." In addition, Dr. Schaaf cited the results of the pulmonary function study and arterial blood gas test conducted by Dr. Zlupko on December 3, 2002, as well as Dr. Pickerill's positive x-ray reading. In conclusion, Dr. Schaaf stated:

> **IMPRESSION:** 1) COAL WORKERS' PNEUMOCONIOSIS.
> This opinion is based on the presence of an abnormal chest x-ray and a compatible history of coal mine employment.
> DYSPNEA DUE TO COAL WORKERS' PNEUMOCONIOSIS.
> This opinion is based on the evidence of lung function impairment manifest as a drop in arterial PO2 during exercise. (The normal response would be a significant increase in PO2 during exercise). Absence of an alternative explanation for his dyspnea.

(DX 28; CX 1). On September 15, 2003, Dr. Schaaf also provided a cursory cover letter, in which he stated, in pertinent part:

> [Claimant] was seen and evaluated in the office today. [Claimant] has coal workers' pneumoconiosis as evidenced on his chest x-ray and supported by a compatible history of coal mine employment. He also has evidence of lung function impairment with an abnormal response of blood gases to exercise. It is my opinion and with a reasonable degree of medical certainty that this is due to his coal workers' pneumoconiosis. His dyspnea by the same degree of certainty is due to coal workers' pneumoconiosis.

(DX 28; CX 1).

Dr. Schaaf also testified at deposition held on July 30, 2004, in which he reiterated his finding of pneumoconiosis arising out of coal mine employment (CX 7, p. 13). Furthermore, Dr. Schaaf opined that Claimant's pulmonary impairment would preclude him from performing his prior coal mine work (CX 7, pp. 19-20).

In a supplemental report, dated October 4, 2004, Dr. Schaaf reviewed the CT scan interpretations by Dr. Harron, and stated that Dr. Harron's findings are consistent with his own opinion that Claimant has pneumoconiosis, as well as his x-ray reading (CX 11).

Dr. John B. Cox, who is Board-certified in Internal Medicine, Pulmonary Medicine, and Allergy & Immunology, examined Claimant on July 23, 2004 (EX 2). On that date, Dr. Cox

issued a report entitled "Black Lung Evaluation," in which he set forth Claimant's history of present illness, past medical history, medication, allergies, family history, social history, and review of systems. Dr. Cox accurately noted that Claimant has been a lifelong nonsmoker. However, Dr. Cox underreported Claimant's coal mine employment history as approximately 9 years, all of which was above ground. Dr. Cox also reported Claimant's subjective complaints of dyspnea and occasional productive cough. On physical examination, Dr. Cox stated, in pertinent part, that Claimant's chest is "clear to auscultation and percussion." Dr. Cox also conducted various clinical studies including a chest x-ray, spirometry, and exercise testing. In summary, Dr. Cox stated:

> **ASSESSMENT:** 69-year-old white male with a history of working in the coal mining industry largely above ground with dust exposure. Now with subjective complaints of dyspnea, exercise tolerance was reduced consistent with deconditioning. Pre-bronchodilator spirometry is invalid. Post-bronchodilator spirometry is normal as are lung volumes. Complete review of the patient's history, and outside records will be completed when the results of laboratory testing are available.

(EX 2). On September 9, 2004, Dr. Cox issued a supplemental report, in which he discussed other available medical data. Based upon the foregoing, Dr. Cox stated:

> In conclusion, [Claimant] is a 69-year-old male with a history of minimal exposure to coal dust working above ground for approximately nine years. He did admit to wearing a respirator. This work was not particularly labor intensive and most of his reasons for leaving work as a supervisor in a nursing home relate to his prior arthritic complaints. He has developed some abnormalities on chest x-ray which were interpreted by Dr. Zlupko as possibly being related to his rheumatoid disease or infection. These have remained stable on follow-up CAT scans. The findings of these on both chest x-ray and CT scan are not specific for coal workers pneumoconiosis. It is my opinion within a reasonable degree of medical certainty that the patient has no conclusive evidence of coal workers pneumoconiosis. He has exercise limitation due to his arthritic complaints and deconditioning. Valid pulmonary function tests have failed to show any significant obstructive or restrictive lung disease. It is my opinion the patient could return to his prior occupation working at a maintenance job for the coal company from a pulmonary standpoint. He may have limitations related to his arthritic disease and prior joint replacements.

(EX 2). Dr. Cox also testified at deposition held on March 16, 2005, and reiterated the above-stated opinion (EX 6). Moreover, Dr. Cox stated that there would be no limitations on Claimant's ability to perform coal mine work from a pulmonary standpoint. On the other hand, Claimant's deconditioning and rheumatoid arthritis cause limitations from a whole-man standpoint (EX 6, p. 19).

Dr. John J. Solic, who is Board-certified in Internal Medicine, Pulmonary Medicine, and Critical Care Medicine, examined Claimant on October 29, 2004 (EX 3). On that date, Dr. Solic

issued a report entitled "Black Lung Evaluation," in which he set forth Claimant's history of present illness, past medical history, family history, social history, and review of systems. Dr. Solic provided an accurate coal mine employment of 22 ½ years, and noted that Claimant has never been a smoker. On physical examination, Dr. Solic stated, in pertinent part, that Claimant's "lung fields are clear to both auscultation and percussion." Dr. Solic also conducted various clinical studies including a chest x-ray, pulmonary function study, and arterial blood gases. Furthermore, Dr. Solic reviewed evaluations by Drs. Zlupko, Schaaf, and Cox. In summary, Dr. Solic stated:

> **IMPRESSION:** 69-year-old white male with significant rheumatoid arthritis with possible bronchiectasis at the right base, previous history of positive PPD, with significant exercise intolerance due to deconditioning, with no definite evidence of pneumoconiosis on chest x-ray.
>
> **PLAN:** A summary letter will be sent to Attorney Bagnato with my conclusions.

(EX 3). On November 23, 2004, Dr. Solic also provided a cover letter, in which he summarized his findings (EX 3). In conclusion, Dr. Solic stated:

> [Claimant is a 69-year-old white male who has worked in mining for a number of years in the past, all above ground. He has never been a smoker. He did not stop mining due to any physical problems. He then worked for another 13 years after leaving the mines. He does have multiple medical problems. He is deconditioned physically. He does have significant both rheumatoid and degenerative arthritis and has had previous joint replacements. He has normal pulmonary function tests with no evidence of either restrictive or obstructive lung disease. He has a normal diffusing capacity. He does have evidence of some atelectasis at the right base and some increased markings, which could be secondary to his bronchiectasis. He has no definite evidence of coal workers' pneumoconiosis. His mild reduction in PO2 with rest, which improved with exercise can be attributed to his atelectasis and mild bronchiectasis. He is not disabled from a pulmonary standpoint. He could return to his previous mining duties based on his pulmonary function testing and his current examination from a pulmonary standpoint. He could not return to the mines based on an overall health standpoint because of his degenerative arthritis and rheumatoid arthritis as well as cardiovascular deconditioning. I do not find evidence of a disabling occupationally acquired pulmonary disorder. All these opinions are expressed with a reasonable degree of medical certainty.

(EX 3). Dr. Solic reiterated the above-stated opinion in his deposition testimony on March 18, 2005, while specifically challenging Dr. Schaaf's opinion regarding the total disability issue (EX 7, pp. 15-16).

Dr. Mathew J. Dvorchak, who is Board-certified in Family Practice, and whom Claimant identified as his longtime family doctor (TR 28), issued an undated, cursory, "To Whom It May Concern" letter (CX 15). The full text of the letter is as follows:

[Claimant] has been under my care since 1-12-1988. In regards to his respiratory history, he has a past history of being retired from Barnes and Tucker Coal Co. with 21.5 years working history as a coal loader and maintenance worker, and does not have a history of smoking. He currently has symptoms of shortness of breath with any exertion, and a chronic cough with sputum production. His latest chest x-ray of 1/12/2006 shows mild obstructive chronic obstructive lung disease with basilar fibrosis. He has had significant pulmonary workup in his past with findings compatible with pulmonary fibrosis and copd. In view of his 21.5 years as a coal worker, and no history of smoking, his findings are in line with occupational exposure. If you require any additional information regarding [Claimant], please feel free to contact me at my office.

(CX 15).

Pneumoconiosis

Section 718.202 provides four means by which pneumoconiosis may be established. Under §718.202(a)(1), a finding of pneumoconiosis may be made on the basis of the x-ray evidence. As stated above, the record contains conflicting interpretations by similarly qualified B-readers and/or Board-certified radiologists. Therefore, I find that the x-ray evidence is inconclusive. Accordingly, Claimant has not established the presence of pneumoconiosis under §718.202(a)(1).

Under §718.202(a)(2), a finding of pneumoconiosis may be made on the basis of biopsy or autopsy evidence. In the absence of any such evidence, this subsection is not applicable.

Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found applicable. In the instant case, the presumption of §718.304 does not apply because there is no evidence in the record of complicated pneumoconiosis. Section 718.305 is inapplicable to claims filed after January 1, 1982. Finally, the presumption of §718.306 does not apply to living miner's claims. Therefore, the Claimant cannot establish pneumoconiosis under §718.202(a)(3).

Under §718.202(a)(4), a determination of the existence of pneumoconiosis may be made if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, find that the miner suffers from pneumoconiosis as defined in §718.201. Pneumoconiosis as defined in §718.201 means a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both "Clinical Pneumoconiosis" and "Legal Pneumoconiosis." *See* 20 C.F.R. §718.202(a)(1) and (2).

As summarized above, the record contains interpretations of chest CT scans, dated March 5, 2003 (DX 43; CX 8) and March 12, 2004 (DX 43; CX 9). Dr. Zlupko reported pulmonary infiltrates and ill-defined alveolar densities without specifying its etiology (DX 43). Dr. Karunaratne also found ill-defined alveolar densities, which he thought were "likely due to pneumonic infiltrates." (DX 43). On the other hand, Dr. Harron stated, in pertinent part, that both CT scan revealed "pea sized opacities consistent with coal workers pneumoconiosis." (CX

8, 9). Dr. Zlupko's curriculum vitae does not set forth any radiological qualifications (DX 13). Furthermore, Dr. Karunaratne's radiological credentials are not in evidence (DX 43). On the other hand, Dr. Harron's curriculum vitae clearly establishes that he is Board-certified in Radiology and Nuclear Medicine (CX 4). In addition, Dr. Harron apparently is also a B-reader, as indicated by the notation on the chest x-ray form report (CX 3). In any event, the record indicates that Dr. Harron's radiological qualifications are superior to those of Drs. Zlupko and Karunaratne. In view of the foregoing, I find that the CT scan evidence establishes the presence of pneumoconiosis.

As outlined above, the record also contains other medical notes, reports and/or deposition testimony of Drs. Zlupko (DX 13, 43; EX 5), Schaaf (DX 28; CX 1, 7, 11), Cox (EX 2, 6), Solic (EX 3, 7), and Dvorchak (CX 15). Although Dr. Zlupko's office notes and CT scan interpretation do not contain a diagnosis of pneumoconiosis (DX 43; EX 5), his more detailed report includes a diagnosis of "radiographic evidence suggestive of simple pneumoconiosis" (DX 13). Furthermore, Drs. Schaaf and Dvorchak also diagnosed pneumoconiosis. On the other hand, Dr. Cox opined that Claimant "has no conclusive evidence of coal workers pneumoconiosis;" and, Dr. Solic found "no definite evidence of coal workers' pneumoconiosis." In view of the CT scan evidence of pneumoconiosis and Claimant's 21+ years of coal mine employment, I credit the findings of pneumoconiosis by Drs. Zlupko, Schaaf, and Dvorchak. Accordingly, I find that Claimant has established pneumoconiosis under §718.202(a)(4).

I have also weighed all the relevant evidence together under 20 C.F.R. §718.202(a) to determine whether the miner suffers from pneumoconiosis. As discussed above, the x-ray evidence, in and of itself, is inconclusive. However, Dr. Harron's CT scan interpretations, which I credit, add further credence to the positive x-ray interpretations. Moreover, as stated above, I find that Claimant has established pneumoconiosis based on the medical opinion evidence. Therefore, taken as a whole, I find that the presence of pneumoconiosis has been established under 20 C.F.R. §718.202(a). *Penn Allegheny Coal Co. v. Williams,* 114 F. 3d 22 (3d Cir. 1997); *Island Creek Coal Co. v. Compton*, 211 F. 3d 203, 2000 WL 524798 (4th Cir. 2000). However, my finding of simple pneumoconiosis herein does not constitute a change in conditions or a mistake in a determination of fact under §725.310, because the District Director also found the presence of pneumoconiosis (DX 21, 47).

Causal Relationship

Since Claimant has established the presence of pneumoconiosis, he is entitled to the rebuttable presumption that the disease arose from his more than ten years of coal mine employment. 20 C.F.R. §718.203. I find that the presumption has not been rebutted. However, this finding also does not constitute a change in conditions or a mistake in a determination of fact under §725.310 (DX 21, 47).

Total Disability

The regulations provide that a claimant can establish total disability by showing the miner has a pulmonary or respiratory impairment which, standing alone, prevents the miner from performing his or her usual coal mine work, and from engaging in gainful employment in the immediate area of his or her residence requiring the skills or abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity over a substantial period of time. *See* 20 C.F.R. §718.204(b)(1). Where, as here, complicated pneumoconiosis is not established, total disability may be established by pulmonary function tests, by arterial blood gas tests, by evidence of cor pulmonale with right-sided congestive heart failure, or by physicians' reasoned medical opinions, based upon medically acceptable clinical and laboratory diagnostic techniques, that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in his usual coal mine work or comparable employment. *See* 20 C.F.R. §718.204(b)(2)(i)-(iv).

As outlined above, none of the pulmonary function studies and/or arterial blood gas studies are qualifying under the criteria stated in Part 718, Appendices B and C. Therefore, Claimant has not established total disability pursuant to §718.204(b)(2)(i) and §718.204(b)(2)(ii), respectively.

There is no evidence which establishes the presence of cor pulmonale with right-sided heart failure. Accordingly, Claimant has also failed to establish total disability pursuant §718.204(b)(2)(iii).

The crux of this case rests on whether Claimant has established the presence of a totally disabling pulmonary or respiratory impairment based on the medical opinion evidence. As fact-finder, I have conducted a qualitative assessment of the medical opinion evidence by analyzing the credibility of each medical opinion considered as a whole, in light of that physician's credentials, documentation, and reasoning.

As outlined above, Drs. Schaaf, Cox, and Solic are all Board-certified pulmonary specialists. On the other hand, Drs. Zlupko and Dvorchak lack this relevant Board-certification. More significantly, Dr. Dvorchak did not address the total disability issue, nor did he cite any specific clinical test results which measure functional impairment (CX 15). Therefore, despite his status as a treating physician, I accord Dr. Dvorchak's opinion little weight regarding the total disability issue.

Of the remaining physicians, Drs. Zlupko, Solic, and Cox agree that, despite Claimant's subjective complaints of dyspnea, he does not suffer from a significant pulmonary or respiratory impairment (DX 13; EX 2, 3, 6, 7). To the contrary, they found that Claimant retains the pulmonary capacity to perform his last usual coal mine job or comparable work. On the other hand, Dr. Schaaf concluded that Claimant's pulmonary impairment would preclude him from performing his prior coal mine work (DX 28; CX 1, 7, 11).

Having carefully weighed the conflicting medical opinions, I accord more weight to the opinions of Drs. Solic and Cox regarding the total disability issue, as buttressed by Dr. Zlupko, than the contrary opinion of Dr. Schaaf. In making this determination, I find that the disability analysis by Drs. Solic and Cox are better reasoned and more consistent with the normal physical

findings on most chest examinations, as well as the credible, objective, clinical test results which reveal little, if any, impairment. Therefore, I find that the better reasoned medical opinion evidence fails to establish the presence of a total (pulmonary or respiratory) disability. Accordingly, Claimant has not established total disability pursuant to §718.204(b)(2)(iv), or by any other means.

Total Disability Due to Pneumoconiosis

Since Claimant has failed to establish the presence of pneumoconiosis and/or that he suffers from a total (pulmonary or respiratory) disability, he clearly cannot establish total disability due to pneumoconiosis, as defined in §718.204(c).

Conclusion

The evidence establishes the presence of pneumoconiosis arising out of Claimant's coal mine employment. However, these findings do not constitute a change in conditions or a mistake in a determination of fact under §725.310 (DX 21, 47). Moreover, Claimant has still not established that he suffers from a totally disabling pulmonary or respiratory impairment. In view of the foregoing, Claimant is not eligible for benefits under the Act and regulations.

Attorney's Fees

The award of an attorney's fee under the Act is permitted only in the cases in which Claimant is found to be entitled to benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the claimant for services rendered to him in pursuit of this claim.

ORDER

It is ordered that the claim of F.J.L. for benefits under the Black Lung Benefits Act is hereby **DENIED.**

A

RICHARD A. MORGAN
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with this Decision and Order you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which this Decision and Order is filed with the district director's office. *See* 20 C.F.R. §§725.458 and 725.459. The address of the Board is: ***Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, D.C. 20013-7601.*** Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. §802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor for Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210. *See* 20 C.F.R. §725.481.

If an appeal is not timely filed with the Board, this Decision and Order will become the final order of the Secretary of Labor pursuant to 20 C.F.R. §725.479(a).

E-FOIA Notice: Under e-FOIA, final agency decisions are required to be made available via telecommunications, which under current technology is accomplished by posting on an agency web site. *See* 5 U.S.C. § 552(a)(2)(E). *See also* Privacy Act of 1974; Publication of Routine Uses, 67 Fed. Reg. 16815 (2002) (DOL/OALJ-2). Although 20 C.F.R. § 725.477(b) requires decisions to contain the names of the parties, it is the policy of the Department of Labor to avoid use of the Claimant's name in case-related documents that are posted to a Department of Labor web site. Thus, the final ALJ decision will be referenced by the Claimant's initials in the caption and only refer to the Claimant by the term "Claimant" in the body of the decision. If an appeal is taken to the Benefits Review Board, it will follow the same policy. This policy does not mean that the Claimant's name or the fact that the Claimant has a case pending before an ALJ is a secret.